	OF HEALTH AND HUM MEDICARE & MEDIC						TED: 10/17/2011 RM APPROVED B NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155223	A. BUI B. WIN		01	COMPLETED 09/26/2011	
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN47932				
` /				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY)		TE	COMPLETION DATE	
K0000	and State Licen conducted by t Department of	h 42 CFR 483.70(a). 9/26/11 r: 000128 er: 155223	K	0000	Preparation and/or executior this Plan of Correction in ger or this corrective action in particular, does not constitut admission or agreement by t facility of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction and speci corrective actions are preparand/or executed in complian with state and federal laws.	neral, e an his he fic red	

Surveyor: Bridget Brown, Life

Safety Code Specialist

At this Life Safety Code survey, The Waters of Covington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This one story facility was determined to be of Type V (000) construction and was fully

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0WQI21

Facility ID:

000128

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155223	B. WING		09/26/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
	05.00.//\050\			LIBERTY ST	
WATERS	OF COVINGTON,	IHE	COVIN	GTON, IN47932	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	=	ne facility has a fire			
	alarm system w				
	detection in the				
		and spaces open			
		s. The facility has a			
		and had a census			
	of 102 at the ti	me of this survey.			
	Quality Review	by Lex Brashear,			
	Life Safety Cod	e Specialist-Medical			
	Surveyor on 09	/29/11.			
	-				
	The facility was				
	compliance wit				
		d requirements as			
	evidenced by:				
K0029 SS=E		d construction (with ¾ hour ran approved automatic fire			
33-E		em in accordance with 8.4.1			
	and/or 19.3.5.4 pro	otects hazardous areas.			
	When the approve				
		em option is used, the areas nother spaces by smoke			
		and doors. Doors are			
	_	on-rated or field-applied			
		nat do not exceed 48 inches			
	from the bottom of 19.3.2.1	the door are permitted.			
	Based on obser	vation and	K0029	K-029 It is the intent of this fa	acility 10/25/2011
	interview, the f		11002)	to insure automatic door clos	
		atic door closers		and latches on hazardous ro	om
	•	hazardous room		doors in 3 of 11 smoke compartments. A. Corrective	e
	doors in 3 of 1			Action Taken: 1. The facility	
	compartments.			installed self-closing devices	and
		is are required to		latches on all hazardous roo	
	TIAZATAOUS ATEA	is are required to		doors - South Skilled Showe	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155223 09/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 E LIBERTY ST WATERS OF COVINGTON. THE COVINGTON, IN47932 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Room, Soiled Laundry access be equipped with self closing door, Medical Records Office and doors or with doors that close Storage Room access door, automatically upon activation of North ICF Brute Storage Room to meet set standards. 2. Medical the fire alarm system. The areas will be stored in a manner to meet of deficient practice could affect such standards.B. Others visitors, staff and 40 or more Identified: 1. All other hazardous residents in the north ICF, the areas of the facility were inspected for this deficiency and center dining room, and south all complied with the set skilled smoke compartments. standards. C. Measures Taken: 1. The Maintenance Findings include: Supervisor/designee will review all hazardous room doors to insure self-closing and latching Based on observations with the mechanisms are in working order maintenance director on 09/26/11 according to set standards. This between 10:00 a.m. and 1:40 will be done monthly as a part of the Preventive Maintenance p.m.: Program. D. How Monitored: 1. a. The south skilled shower room The CEO/designee will review the was used for the collection of results of the monthly audits at the quarterly QA & A Committee soiled linen and trash receptacles. meetings. E. This plan of The door was not self closing. correction constitutes our credible b. The soiled laundry access door allegation of compliance with all had no latch. regulatory requirements, our date of completion is 10/25/2011. c. The medical records office and storage room access door had no self closer. Records were stored in combustible plastic bins and cardboard cartons in the room. d. The north ICF brute storage room housing two large brute storage containers for the collection of soiled linens and trash did not latch.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155223	B. WIN			09/26/2	011
WATERS	PROVIDER OR SUPPLIER OF COVINGTON,	THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN47932				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
K0038 SS=E	The maintenan acknowledged observations the hazardous area and latching as 3.1–19(b) Exit access is arrareadily accessible with section 7.1. Based on observations the mean through 1 of 12 equipped with was readily accessidents withous requires doors means of egressequipped with requires the usefrom the egress No. 1 requires arrangements we gress shall be care occupancion to be alth care occupancion to be accession of the electron of the egress shall be care occupancion to be accession of the electron occupancion the electron of the electron occupancion	at the time of the doors to these as were not closing required. Inged so that exits are at all times in accordance 19.2.1 Evation and acility failed to this of egress 2 exit doors magnetic locks, essible for that a clinical firing specialized tres. LSC 19.2.2.2.4 within a required as shall not be a latch or lock that the of a tool or key is side. Exception door locking without delayed permitted in health these, or portions of upancies, where dis of the patients ared security their safety,	KO	0038	K-038 It is the intent of this facility to insure the means of egress through 1 of 12 exit doors equipped with magnetic locks readily accessible for residen without a clinical diagnosis requiring specialized security measures. A. Corrective Action Ta 1. Maintenance Super replaced the 9 volt battery an also posted information to achieve the pass code to ove the lock in the event of equip malfunction. B. Others Identified: 1. Maintenance Super tested all other emergency exidoors and no other issues we found. C. Measures Taken: 1. Maintenance Supervisor/designee will do a visual and functional test of a emergency exit doors to verif they meet set standards morn as a part of the Preventive Maintenance Program.	s, is sken: visor ad erride ment visor xit ere	10/25/2011

li '		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155223	B. WING		09/26/2011
NAME OF I	DROWIDED OD CUIDDI IED		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		1600 E	E LIBERTY ST	
	OF COVINGTON,	THE	COVIN	NGTON, IN47932	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG			IAG	D. How Monitored:	DATE
		ors at all times.		1. The CEO/designed	will
	This deficient p			review the results of the mor	I
	· ·	nd 27 residents on		audits at the quarterly QA &	Α
	the Horizons u	nit.		Committee meetings. E. This plan of correct	ion
	Findings includ	e:		constitutes our credible alleg of compliance with all regula requirements, our date of	ation
	Based on obser	vation with the		completion is 10/25/2011.	
	maintenance di	irector on 09/26/11			
	at 12:10 p.m.,	the south			
	emergency exit	door on the			
	Horizon unit wa	as magnetically			
	locked. A keyp	ad adjacent to the			
	door frame was	identified by the			
	maintenance di	irector as the			
	override for the	e magnetic lock and			
	a code to unloc				
	posted. Howev	er. when the			
	-	as entered, the door			
	remained locke				
		rector attempted to			
		r using the posted			
		ed to unlock. He			
		nother code which			
		or to open. He said			
		lemonstration, the			
		ine volt battery			
	· ·	•			
	backup and if t	·			
	"low" the code	•			
	revert back to t				
		code setting. He			
		d, staff working on			
	the unit with re	sidents would not			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY O1 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155223	A. BUII	LDING	01	09/26/2	
		199223	B. WIN			09/20/2	.011
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WATERS	OF COVINGTON,	THE		1	LIBERTY ST GTON, IN47932		
		TATEMENT OF DEFICIENCIES	_		1		(V.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	know how to ov	verride the lock if					
	the door lock fa						
		of the fire alarm					
	•	code did not allow					
	the door to unl						
	the door to am						
	3.1-19(b)						
K0048		plan for the protection of all					
SS=F		eir evacuation in the event					
	of an emergency.		17.0	0040	K-048		10/25/2011
	Based on record		K	0048	N-040		10/25/2011
	interview, the fa	•			It is the intent of this facility to	0	
	•	lete written fire			insure the provision of a com	-	
	= =	ressing all items			written fire safety plan addre all items required by NFPA 1	•	
	required by NFI				all items required by Ni i A i	01.	
	edition, Section				A. Corrective Action Ta	aken:	
	•	es a written health			1. The facility has revi		
		fire safety plan			the Disaster Manual to include policy and procedure to resp		
	that shall provi	de for the			to battery-powered smoke	ona	
	following:				detectors and alarms and rev		
	(1) Use of alarm				the RACE procedure direction	ns to	
		n of alarm to the			meet set standards. B. Others Identified:		
	fire department				All occupants have	the	
	(3) Response to				potential to be affected.		
	(4) Isolation of				C. Measures Taken: 1. All staff were inserv	iood	
	, ,	of immediate area			on the revisions to the Disas		
	(6) Evacuation (ot smoke			Manual.		
	compartment	6.61			D. How Monitored:		
	(7) Preparation				The Maintenance Supervisor/designee will revi	iow.	
	building for eva				revisions and procedures at	CVV	
	(8) Extinguishm				monthly fire drills.		
		ractice could affect			2. The CEO/designee		
	all occupants ir	the event of an			review the fire drill document at the quarterly QA & A	ation	
					at the quarterly QA & A		

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223		LDING IG	NSTRUCTION 01	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		1600 E	DDRESS, CITY, STATE, ZIP CODE LIBERTY ST GTON, IN47932	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	emergency who plan should be available. Findings includ	·		Committee meetings. E. This plan of correct constitutes our credible allest of compliance with all regular requirements, our date of completion is 10/25/2011.	gation	
	maintenance d from 10:35 a.n required eleme and procedure Plan were miss different and spolicy and procedure plan. The main had the policy He acknowledge record review, included in the manual provide stations. The R an element of the included confliction of the use of the lextinguisher low in relationship kitchen hood e	ACE procedure was the Fire Plan but it cting directions to page 13 of the fire nguish on page 14. o policy addressed K class fire cated in the kitchen with the use of the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0WQI21 Facility ID:

000128

If continuation sheet

Page 7 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY O1 COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155223	A. BUILDING	01	09/26/2011
		100220	B. WING	DDDEGG CITY CTATE ZIR CODE	09/20/2011
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST	
	OF COVINGTON,			GTON, IN47932	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
1710			1710	·	DATE
		staff on 09/26/11 evealed they had			
	•	•			
		d in the special			
		r use of the K class			
	~	Γhe review date for the disaster book			
		a posted plan was			
	noted to be 200				
	maintenance di				
		the inconsistencies			
	_	ne record review			
	and tour.	ie record review			
	and tour.				
K0051 SS=F	according to NFPA Code, to provide e any part of the buil complete fire alarm alarm initiation, au extinguishing syste in patient sleeping provided that man 200 feet of nurse's located in the path written records of or reliable second so Fire alarm systems accordance with N maintenance are k is remote annuncia	n with approved ces or equipment is installed a 72, National Fire Alarm effective warning of fire in Iding. Activation of the in system is by manual fire tomatic detection or em operation. Pull stations areas may be omitted ual pull stations are within is stations. Pull stations are i of egress. Electronic or tests are available. A urce of power is provided. IFPA 72 and records of teept readily available. There ation of the fire alarm oved central station.			
	Based on obser interview, the fa maintain 1 of 1		K0051	K-051 It is the intent of this fat to insure to maintain 1 of 1 final alarm systems in accordance NFPA-72. A. Action Taken:	re e with

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO ILDING	INSTRUCTION 01	(X3) DATE S COMPL		
		155223	B. WIN			09/26/2	011
WATERS	PROVIDER OR SUPPLIER	THE		1600 E	ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST GTON, IN47932		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Edition. NFPA requires the fir disconnecting red marking, s only to authori shall be identificated could as well as visited. Findings includes well as visited as well as visited. Findings includes as well as visited as well as visited as well as visited as well as visited. Findings includes as well as visited at 12:10 p.m., system circuit the emergency lacked identified the breaker bothe door for the housing the brunlocked. The director said at observation, he fire alarm circuit	larm Code, 1999 72, 1-5.2.5.2 The alarm circuit Imeans shall have a shall be accessible are personnel, and fied as FIRE ALARM ROL. This deficient affect all residents for and staff. The circuit affect on 09/26/11 the fire alarm breaker located in a power breaker box that affect and e mechanical room eaker box was maintenance			The Maintenance Supervisor clearly identified the fire alarr circuit breaker that controls emergency power to the fire alarm system to meet set standards. 2. The Maintenar Supervisor has installed a store-room function door lock to insure the Mechanical Rood door is locked at all times. B. Others Identified: 1. There is other emergency power brea boxes. C. Measures Taken: Maintenance Supervisor/designee monitor proper breaker identification that the Mechanical Room is locked upon weekly rounds. How Monitored: 1. The CEO/designee will review the results of the weekly rounds results at the quarterly QA & Committee meetings. E. Thi plan of correction constitutes credible allegation of complia with all regulatory requirement our date of completion is 10/25/2011.	nce s set om s no ker 1. e A s our	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR O1 COMPLETE A. BUILDING						
		155223	B. WIN			_	09/26/2	011
	ROVIDER OR SUPPLIER		<u> </u>	1600 E	ADDRESS, CI LIBERTY GTON, IN4			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CO	ORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIAT	re .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	ONOGO NE	DEFICIENCY)		DATE
K0062 SS=E	continuously main condition and are i	ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA						
	1. Based on ob	servation and	K(0062	K-062			10/25/2011
	interview, the f	acility failed to			lt is tha	intent of this facility to	,	
	ensure sprinkle	r heads providing				that sprinkler heads		
	protection in 3	of 11 smoke			providir	ng protection in 3 of 1	1	
	compartments	and protected areas				compartments and	1	
	were maintaine	d. This deficient				ed areas are maintain are 1 of 1 sprinkler he		
	practice affects	visitors, staff and				ing the Activity Room	,aas	
	20 or more res	idents in the south			Storage	e Room has a minimu		
	Fountain unit, t	he dining room				tion of 4 inches from t	he	
	smoke compart	tment, the entry,			wall			
	and the center	skilled smoke			A.	Action Taken:		
	compartment.				1.	The Maintenance		
	Findings includ	e:			sprinkle escutch missing	isor and a licensed er contractor have rep neons and replaced al g escutcheons and ha	I	
	a) Based on ob	servation with the				d the front entrance		
	maintenance di	rector on 09/26/11			canopy	to meet set standard: A licensed sprinkler		
	between 10:00	a.m. and 1:40 p.m.			I	ctor has relocated the		
	sprinkler head	escutcheons were				er head in the Activity		
	missing and/or	displaced in the				Storage Room to mee	t set	
	south Fountain	unit janitor's			standar B.	Others Identified:		
	closet, the med	lical records			1.	All other areas of th	ne	
	storage room n	ear the Fountain				g were inspected to in		
	unit nurses' sta	tion, the main				ance with set standard other issues were fou		
	dining room, a	nd the physical			C.	Measures Taken:	ıııu	
	therapy room.				1.	Maintenance		
	,	oservation with the rector on 09/26/11			comple above o	isor/designee will te audits regarding the cited deficiencies as a nonthly Preventive		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	01	COMPL	ETED
		155223	B. WIN			09/26/2	011
		I	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	LIBERTY ST		
WATERS	OF COVINGTON,	THE		1	GTON, IN47932		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	at 1:35 p.m., o	ne sprinkler			Maintenance Program.		
	providing prote	ection under the			D. How Monitored:1. The CEO/designee	varill	
	entrance canor	by was missing. The			review the results of the mo		
	·	d in with a caulking			audits at the quarterly QA &	•	
	material. The				Committee meetings.		
	director said at				E. This plan of correct		
	observation, th				constitutes our credible alleg		
					of compliance with all regula requirements, our date of	югу	
	enough protec				completion is 10/25/2011.		
	· ·	vided. He could			p 2		
	l -	cumentation from					
	the sprinkler co	ontractor which					
	would support	his opinion.					
	3.1-19(b)						
	3.1-19(b)						
	2. Based on ol	oservation and					
	interview, the f	acility failed to					
	ensure 1 of 1 s	•					
		activities room					
	I .	nad a minimum					
	_						
		our inches from a					
		4-7.3.3 requires					
	sprinklers shal						
		ur inches from a					
	wall. This defi	cient practice could					
	affect staff, vis	itors and four or					
	more residents	in the activities					
	room.						
	Findings institut	lo.					
	Findings include:						
	Based on observation with the						
		irector on 09/26/11					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155223	B. WING			09/26/2	011
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1600 E	LIBERTY ST		
	OF COVINGTON,				GTON, IN47932		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	COMPLETION DATE
IAU				IAU			DATE
	•	a single sprinkler					
	=	protection for the					
	storage room i						
		inkler was located					
	two and one fo	urth inches from					
	the wall separa	ting it from the					
	activities room	. The distance was					
	measured with	and acknowledged					
	by the mainten	ance director to be					
	less than the m	inimum four inches					
	allowed.						
K0064 SS=D	health care occupa	guishers are provided in all ancies in accordance with 5, NFPA 10					
	Based on obser	observation and		K0064	K-064 It is the intent of this facilit		10/25/2011
	interview, the f	acility failed to			to insure that 1 of 2 portable fire		
	maintain 1 of 2	•			extinguishers in the kitchen cooking area is maintained ir	,	
	extinguishers i	-			accordance with the requirements		
	•	accordance with			of NFPA 10. A. Corrective A		
	the requiremen				Taken: 1. The Maintenance		
	Standard for Po				Supervisor has installed a pla next to the K-Class fire	acard	
		1998 Edition. NFPA			extinguisher located in the ki	tchen	
	10, 2–3.2 requ				area to meet set standards.		
		provided for the			Others Identified: 1. The fac	ility	
	-	ooking appliances			has only 1 K-Class fire extinguisher. C. Measures		
		le cooking media			Taken: 1. The Maintenance		
		nimal oils and fats)			Supervisor/designee will aud	it the	
	shall be listed a				K-Class fire extinguisher to n		
					set standards as a part of the		
		NFPA 10, 2-3.2.1			monthly Preventive Maintena Program. D. How Monitored		
	requires a place				The CEO/designee will revie		
	conspicuously	placed near the			results of the monthly audits	at	
			ı	I		,	

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	Ì	LDING IG	NSTRUCTION 01	(X3) DATE COMPI 09/26/2	LETED
	PROVIDER OR SUPPLIER OF COVINGTON,			1600 E	ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST GTON, IN47932		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	extinguisher was protection systematically sactivated prior extinguisher. So automatically source to the country activated before fire extinguished the portable fire extinguished the portable fire supplemental protection or more resided dining room, lot the kitchen. Findings include Based on obsermaintenance do at 12:40 p.m., place above the extinguisher lot to notify occup be used until a extinguishing sactivated. The director said at observation, he the need for the extinguishing is activated. The director said at observation, he the need for the extinguishing is activated.	hich states the fire em shall be to using the fire Since the fixed fire system will hut off the fuel ooking appliance, m should be e using a portable er. In this instance, re extinguisher is protection. This ce could affect 20 nts using the main pocated adjacent to le: rvation with the irector on 09/26/11 no placard was in e K class fire ccated in the kitchen hants it was not to fter the fixed fire system had been maintenance the time of e was unaware of			the quarterly QA & A Commmeetings. E. This plan of correction constitutes our crallegation of compliance wit regulatory requirements, ou of completion is 10/25/2011	edible h all r date	
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0WQI21 Facility ID:

000128

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155223	B. WINC			09/26/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
	OF COVINGTON,	THE			GTON, IN47932		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC1)		DATE
K0066 SS=E	• •	ns are adopted and include illowing provisions:					
	or compartment w combustible gases stored and in any and such area is p	hibited in any room, ward, here flammable liquids, s, or oxygen is used or other hazardous location, costed with signs that read with the international king.					
		tients classified as not nibited, except when under					
	(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.						
	devices into which	rs with self-closing cover ashtrays can be emptied le to all areas where ed. 19.7.4					
	Based on obser	vation, record	K0	066	K-066		10/25/2011
	review, and inte	erview, the facility			It is the intent of this facility to		
		e a complete, and			It is the intent of this facility to insure the provision of a com		
	enforce, an effe	-			and enforcement of an effect		
	policy for 1 of 2	2 smoking areas.			smoking policy for 1 of 2 smo	oking	
		oractice could affect			areas.		
		and any resident in			A. Corrective Action Ta	ıken:	
		outdoor smoking			The identified smoken in the identified s	-	
	_	tween the kitchen			areas have been cleaned and	d	
	and north skille				ashtrays of non-combustable	;	
	Findings includ				material and safe design are provided in designated smok areas. B. Others Identified: 1. All designated smol	Č	
	Based on recor	d review with the			 All designated smol areas have been audited to r 	-	
	maintenance di	rector on 09/26/11			set smoking standards.		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	Ĺ	LDING	NSTRUCTION 01	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER			1600 E	DDRESS, CITY, STATE, ZIP CODE LIBERTY ST STON, IN47932		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Smoking Policy was permitted designated are noted the "des smoking is loci include an app The maintenan receptacles we which these de could be identiarea between to north skilled u with the mainto 09/26/11 at 1 had two self clashtrays on two tables and a not smoking tower corridor exit per the area. The the picnic table with cigarette latwo unoccupied cigarette butt I third table was staff who were no ashtray. Staflicking cigarette ground and on	as. The policy ignated area for ated outside to ropriate receptacle". ce director said the re the means by signated areas fied. The smoking he kitchen and nit was observed enance director on 2:15 p.m. The area osing metal o of three picnic oncombustible outside the service roviding access to ground surrounding es was carpeted outs. Ashtrays on d tables were full. d table had a ying upon it. A occupied by four smoking and had aff were observed te ash onto the e staff had a e with a cigarette			C. Measures Taken: 1. The CEO/designed audit designated smoking ar weekly to meet set standard D. How Monitored: 1. All audit results wil reviewed at the quarterly QA Committee meetings. E. This plan of correct constitutes our credible alleg of compliance with all regular requirements, our date of completion is 10/25/2011.	eas s l be a & A ion action	

000128

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTIO	N	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	155223	A. BUII		01		09/26/2	
			B. WIN		DDRESS CI	TY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			l	LIBERTY			
	OF COVINGTON,			l	GTON, IN4			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		VIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG		DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	another cigaret	·	+	ING				DATE
	_	irector said at the						
	time of observation, he picked up the cigarette butts from the							
	ground but agr							
	-	"there should have						
	• •							
been" an ashtray on the smoker's table.								
K0068 SS=E	3.1–19(b) Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 4 boiler/service water heater (SWH) rooms was provided with outside intake combustion air for a room housing fuel fired equipment. This deficient practice could affect visitors, staff and 8 residents in the center skilled smoke compartment. Findings include: Based on observation on 09/26/11 at 12:20 p.m. with the maintenance director, a fuel fire SWH was housed in a room in the center skilled smoke		KO	0068	insure to water how with our for a room equipmed. A. 1. Superviolair intake B. 1. water how to meet C. 1. Superviolair intake compension in the compension	Corrective Action Ta The Maintenance isor has installed a fre ke to meet set standar Others Identified: All other boiler/serv reater rooms were auch set standards. Measures Taken: The Maintenance isor/designee will con y audits to insure set rds are met as a part of y Preventive Maintenance	ce ided on air aken: esh rds. ice dited duct of the ance	10/25/2011

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155223	B. WIN			09/26/2	011
			B. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	LIBERTY ST		
WATERS	OF COVINGTON,	THE		l	GTON, IN47932		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
		vledged at the time			review the results of the mon audits at the quarterly QA & A	-	
	of observation	the room had no			Committee meetings.	`	
	fresh air intake.				E. This plan of correcti	on	
	3.1-19(b)		constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.				
K0076 SS=E		ge and administration areas ccordance with NFPA 99, lth Care Facilities.	Competion is 10/20/2011.				
		e locations of greater than closed by a one-hour					
		upply systems of greater re vented to the outside. , 19.3.2.4					
	Based on obserinterview, the feedsure a reside smoke comparts store oxygen with a store oxygen with a store oxygen with a store oxygen with a store oxidizing agents. This deficient p	vation and acility failed to acility failed to act room in 1 of 11 aments used to as separated by ath a one hour fire ag. NFPA 99, uires storage for gases shall comply NFPA 99, quires at least one ant enclosures shall at the storage of ats such as oxygen. bractice affects and 12 residents in	K	0076	K-076 It is the intent of this facility to insure that 1 of 11 resident rosmoke compartments used to store oxygen is separated by construction with a 1-hour fire resistance rating. A. Corrective Action Ta 1. The facility has corrected Room 47 to meet standards. B. Others Identified: 1. An audit of all other rooms has been completed to insure compliance with set standards. C. Measures Taken: 1. The Director of Nursing/Designee will audit a resident rooms weekly to insuthey meet set standards.	ooms o e aken: set	10/25/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION 24	li i	ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155223	A. BUILDING	<u>01</u>	- 09/26/	PLETED 2011
		133223	B. WING			2011
NAME OF F	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CO DE LIBERTY ST	DE	
WATERS	OF COVINGTON,	THE	l l	INGTON, IN47932		
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	1		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
	Findings includ Based on obser maintenance di at 11:55 a.m., to containers (181 one e-cylinder resident room door was not excloser and they did not provide resistance ratin oxygen storage cannula was attoxygen containers in the the resident has attached to one two tanks at the was notified the arrangement in inspected the oxy resident was sucontainer. She unaware the refor two contains	de: Evation with the director on 09/26/11 of three liquid oxygen of L capacity) and were observed in 47. The unrated quipped with a self walls and ceiling of a one hour fire of required for the areas. A nasal tached to one liquid of the area of observation observation of observation observation of observation		CROSS-REFERENCED TO THE AP	ed: signee will ne audits at Committee correction e allegation regulatory e of	
	the room.					

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	A. BUII	LDING	NSTRUCTION 01	(X3) DATE S COMPL 09/26/2	ETED
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		B. WIN	1600 E	LIBERTY ST GTON, IN47932 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	(X5) COMPLETION DATE	
K0130 SS=F	1. Based on resobservation and facility failed to swinging fire do the kitchen in a NFPA 80, 1999 for Fire Doors a NFPA 80, 2–1.2 assemblies shad components the products incorpassembly and at their own subcoincluding a late 2–1.4.1 required doors swing freat a self closing door to close a activation of the deficient practivisitors and and residents in the Findings include Based on obsermaintenance did at 1:00 p.m. two between the kitchen and the self-self-self-self-self-self-self-self-	d interview, the maintain 2 of 2 cor sets protecting accordance with Edition, Standard and Fire Windows. Trequires fire door at are separate corated into the allowed to have components. The NFPA 80, as self closing fire ely and easily with evice to cause each and latch upon the fire alarm. This are affects staff, and 20 or more the dining room. The electron of th	K	0130	K-130 It is the intent of this facility to insure that 2 of 2 swinging fir door sets protect the kitchen accordance with NFPA 80 an insure 3 of 3 service water heaters have current certificated inspection. A. Corrective Action Ta 1. A certified contractor have repaired the swing fire door so to meet set standards. 1. All water heaters have been inspected by a certified contractor to meet set standards. 1. The facility has only 1 kitchen area and no other do are affected. 2. All water heaters have been checked to meet set standards. C. Measures Taken: 1. The Maintenance Supervisor/designee will aud 2 swing fire door sets and was heater inspection certificates monthly as part of the Prevental Maintenance Program. D. How Monitored: 1. The CEO/designee review the results of the monaudits at the quarterly QA & A Committee meetings. E. This plan of correctic constitutes our credible allegements.	te in ad to ates aken: as sets ave ards. ave it the ater ative will athly A	10/25/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223			LDING	NSTRUCTION 01	(X3) DATE (COMPL 09/26/2	ETED
	PROVIDER OR SUPPLIER		 1600 E	ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST GTON, IN47932		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	swinging fire depth by magnets what activation of the Only one door was equipped addition, both close and latch from their magnetics. The nacknowledged observation, the provide protect room in the event of the eve	loor sets held open nich released upon he fire alarm system. in each door set with a latch. In door sets failed to when released gnetic hold open naintenance director at the time of hese doors could not tion for the dining ent of a kitchen fire. Deservation, record erview, the facility e 3 of 3 service (SWH) had tificates of C 19.1.1.3 requires ties to be ad operated to possibility of a fire	TAG	of compliance with all regula requirements, our date of completion is 10/25/2011.		DATE
	L					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE S COMPLI		
		155223	A. BUILD B. WING			09/26/20		
	PROVIDER OR SUPPLIER		p. wate	STREET AI	FREET ADDRESS, CITY, STATE, ZIP CODE 600 E LIBERTY ST OVINGTON, IN47932			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\top	ID			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	_	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Findings includ	e:						
	Based on obser	vation of SWH						
	rooms with the maintenance							
	director on 09/	26/11 between						
	10:00 a.m. and	1:40 p.m. posted						
	certificates of i	nspection had						
	expired on 08/18/11 for vessels #290018, #262766, #262767 in the sprinkler mechanical room and activities room. One other SWH							
	accessed from an exterior building							
	entry door near	the generator was						
	also expired. T	he maintenance						
	director said at	the time of						
	observation, th	e inspection						
	arrangements v	vere to be made by						
	the regional ma	aintenance director						
	and had not be	en done.						
K0144 SS=F		spected weekly and ad for 30 minutes per ace with NFPA 99.						
	Based on obser	vation and	K01	144	K-144		10/25/2011	
	interview, the f	acility failed to			It is the intent of this facility to	,		
	ensure 1 of 1 e	mergency			insure that 1 of 1 emergency			
	generators was	equipped with a			generators is equipped with a			
	remote manual stop. LSC 7.9.2.3				remote manual stop.			
	requires emerg	ency generators			A. Corrective Action Ta	ıken:		
	providing power	er to emergency			 A licensed generate 	- 1		
	lighting system	s shall be installed,			contractor has installed an			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0WQI21 Facility ID:

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If continuation sheet

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SERVET ADDRESS. CITY. STATE. LIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION O1			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE WATERS OF COVINGTON, THE SUMMARY STATEMENT OF DEFICIENCIES REAGLATION OF LISC IDENTIFYING INFORMATION) TAG REAGLATION OF LISC IDENTIFYING INFORMATION) TESTED AND OF LISC IDENTIFYING INFORMATION INF	THIS TETH	or conduction						
WATERS OF COVINGTON, THE WATERS OF COVINGTON, IN47932 AND DESCRIPTION SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST IBS PERCEDED BY BULL TAGGET OF THE MUST INFORMATION TO A COMPLETION DATE THE STATEMENT OF DEFICIENCE TO THE MUST INFORMATION TO A COMPLETION DATE THE STATEMENT OF DEFICIENCE TO THE MUST INFORMATION TAGGET OF THE MUST INFORMATION TO THE MUST INFORMATION THE M				B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
Oxidea Description Complete	NAME OF I	PROVIDER OR SUPPLIER	R					
REACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.66 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 09/26/11 at 12:15 p.m. the emergency generator. At the time of observation the maintenance director was asked if	WATERS	OF COVINGTON,	THE		COVIN	GTON, IN47932		
tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3–5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8–2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 09/26/11 at 12:15 p.m. the emergency generator. At the time of observation the maintenance director was asked if						PROVIDER'S PLAN OF CORRECTION		
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Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 09/26/11 at 12:15 p.m. the emergency generator was larger than 100 horsepower. An emergency stop was observed on the generator. At the time of observation the maintenance director was asked if						•		
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requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 09/26/11 at 12:15 p.m. the emergency generator was larger than 100 horsepower. An emergency stop was observed on the generator. At the time of observation the maintenance director was asked if		I	=					
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At the time of observation the maintenance director was asked if		horsepower. A	n emergency stop					
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there was a remote emergency		maintenance d	irector was asked if					
		there was a rer	mote emergency					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155223	B. WIN			09/26/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u>"</u>	•		DDRESS, CITY, STATE, ZIP CODE		
WATERS	OF COVINGTON,	THE	1600 E LIBERTY ST COVINGTON, IN47932				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	l	nerator. He said he					
	would shut the	gas supply valve to					
	the generator to stop it in the						
	event of an em	ergency. There was					
	no other remot	te means to stop the					
	generator.						
K0147 SS=E	accordance with N Code. 9.1.2 Based on observing, the fensure 1 of 1 from the second s	facility failed to lexible cords were substitute for fixed 70 (National), 1999 Edition, requires that, unless mitted, flexible res shall not be used for fixed wiring of his deficient practice raff, visitors and 7 or in the physical compartment. de: rvation with the irector on 09/26/11 a.m. and 1:40 rip extension cords	KO	0147	K-147 It is the intent of this facility to insure that 1 of 1 flexible convere not used as a substitute fixed wiring. A. Corrective Action Tat. The power strip extension cord was removed Room 12. B. Others Identified: 1. All resident rooms and audited to verify that they make set standards. C. Measures Taken: 1. The Maintenance Supervisor/designee will commonthly audits of all resident rooms to meet set standards part of the monthly Preventive Maintenance Program. D. How Monitored: 1. The CEO/designee review the results of the more audits at the quarterly QA & Committee meetings. E. This plan of correct constitutes our credible allegement of the substitutes our credible allegement.	ds e for aken: d from were eet duct t sas a ve e will athly A	10/25/2011

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	(X2) MULTIPLE CO A. BUILDING B. WING	01	i .	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		1600 E	ADDRESS, CITY, STATE, ZIP CO LIBERTY ST GTON, IN47932	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE PROPRIATE	(X5) COMPLETION DATE
	and a nebulize concentrator ir maintenance d time of observa	room 76. The irector said at the ations, the use of as nor permitted for		of compliance with all requirements, our date completion is 10/25/20	e of	